HEALTH CARE SERVICES

Industry Sector Analysis [ISA]

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Country: **SOUTH AFRICA**

Industry: **Health Technologies**
Sector: **Health Care Services**

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SUMMARY

South Africa has a population of approximately 43 million. Although classified as a middle-income country, it is estimated that between 35 and 55 percent of the population live in poverty and lack access to basic services including healthcare, clean water and sanitation.

Despite its transformation into democracy in 1994, South Africa still exhibits major disparities and inequalities in income and access to services. The poorest 40% of the households earn less that 6% of total income, while the richest 10% earn more than half.

Despite the decline in the value of the Rand vs. the Dollar, South Africa continues to offer immediate and long-term opportunities for the U.S. companies with the right products, services, resources and commitment to the market.

The delivery of health care services (HCS) in South Africa is managed by two systems:
- The public health care system, which is mainly government subsidized and serves the bulk of the population, and
- The private health care system, which is administered by health insurance programs and only serves a few people who can afford medical aid coverage/insurance.

The two systems are distinct and have different priorities, standards and needs. The private sector system is classified by Western-standard facilities. With the introduction of managed care in the private sector system, there is an increased need for U.S. expertise in the area of cost management. The public sector is undergoing tremendous changes in both its administration and facilities. The opportunities for U.S. companies in the public sector are in the supply of sophisticated medical equipment.

Table 1: Comparison of Health Personnel Practicing In the Private vs. Public Sector

CATEGORY TOTAL SOUTH AFRICA NUMBER IN PRIVATE % IN PRIVATE SECTOR
General Practitioners 17438 10067 57.7
Specialists 6342 3657 57.7
Dentists 3748 3330 88.8
Pharmacists 15794 14841 94.0
Nurse 119922 6586 13.8

South Africa spends approximately 8.5% its GDP on health care, about 60% in the private sector. The Government priority since 1994 has been to improve access to primary health care. In 1997, the White Paper on the Transformation of the Health Sector stated that 'the activities of the public and private health care sectors should be integrated in a manner that makes optimal use of all available health care resources. The public-private mix in healthcare should promote equity in service provision.

There are various reasons why public-private partnerships (PPP) are being explored in the health sector. One major reason is that the historical interaction between the public and private sectors has not been positive, and has resulted in a strong negative net effect on the public sector.

- Firstly, the rapid expansion of the private hospital sector in recent years has undermined public provision by draining large numbers of highly skilled staff and paying patients out of the public hospital system.
- Secondly, the private health insurance system also exploits public hospitals by dumping expensive cases once insurance benefits have been exhausted in private hospitals.
- Thirdly, insured patients frequently claim to be uninsured and do not pay for care at public hospitals.

These factors have translated into a fairly substantial subsidy from the public to the private sector. An inadequate regulatory environment has helped to exacerbate the situation. PPPs are therefore seen as one way to tap into the concentration of resources to the benefit of all citizens.

The Department of Health has also built new clinics in rural areas where health facilities were previously not accessible. The government has also imported doctors from Cuba and Germany to help alleviate the shortage of doctors in rural South Africa. Although progress has been made, more is needed to ensure that all South Africans, especially those in rural and impoverished areas, have adequate access to health care services.

Since 1997, the health budget allocations have been decentralized. The national budget allocates specific amounts to each province, which has the responsibility to develop its own budget. Therefore, Provinces make their own capital-investment decisions.

A. MARKET OVERVIEW

Market analysts have pointed out that the increase in health expenditure over the next three years would average 7,3% per annum, which is on par with the other social services but, overall, less than the consolidated national expenditure which will increase by 8,1% per annum over the next three years. This means that spending on health is falling behind.

South Africa has well developed high technology hospitals in the main cities, but only the basic underdeveloped health care facilities and services in rural areas. As a consequence, the poorer two thirds of the population do not have

full access to essential health care services. The Government developed a district health system in rural areas to deliver integrated primary health care and hospital services.

A huge imbalance still exists in spending between the public and private health care sectors. Out of a total national health budget of about 70 billion Rands(US$10 billion), only 10% of the total health care expenditure is in the public sector, which represents over 80% of the total population.

The Government has taken steps to rectify this imbalance and raise the standard of health care to that of the private health care system by:

- Increasing Public Private Partnerships (PPP) which are seen as one way to tap into the concentration of resources to the benefit of all citizens.
- Setting a medium term goal so that the average number of public primary health care (PHC) consultations per person are raised from 2.8 to 3,5 by 2005 (See Table 3).

The Department of Health believes that it will be possible and affordable to provide basic health care to all South Africans within the next 8 years. The Government expects significant growth in Public Health Care expenditure (9%) until it constitutes 26% of the annual budget. The Department of Health assumes real growth of 3.6% for the whole Health budget.

Table 3: Expected Increase in Use of Public PHC Services

Quintiles of magisterial districts (% total) by average income	(previous) Population per person 2000/01	Average Annual Consultations per person 2005/06
Top 37	2,8	3,5
Bottom Four 63	2,8	3,5
TOTAL 100	2,8	3,5

(1 Derived from McIntyre, D. et al., Health Expenditure and Finance in South Africa, Health Systems Trust and World Bank, Durban, 1995)

Table 4: Number of Hospitals and Beds (2000)

SOUTH AFRICA

Province	Type of Institution	No. of Hospitals	Number of Beds Private	Public	TOTAL
Western Cape	Public Hospitals	45	-	-	11680
Western Cape	Private and Aided Hospitals	68	1097	4344	5441
Eastern Cape	Public Hospitals	65	-	-	17059
Eastern Cape	Private and Aided Hospitals	39	611	3172	3783
Northern Cape	Public Hospitals	19	-	-	1955
Northern Cape	Private and Aided Hospitals	29	106	851	957
KwaZulu-Natal	Public Hospitals	64	-	-	26562
KwaZulu-Natal	Private and Aided Hospitals	50	1165	5520	6685
Free State	Public Hospitals	31	-	-	5117
Free State	Private and Aided Hospitals	19	428	2041	2469
Gauteng	Public Hospitals	28	-	-	17868
Gauteng	Private and Aided Hospitals	113	5168	10400	15568
Mpumalanga	Public Hospitals	28	-	-	4568
Mpumalanga	Private and Aided Hospitals	11	226	877	1103

Northern Province Public Hospitals 44 - - 12895
Northern Province Private and Aided Hospitals 2 106 273 273
North West Province Public Hospitals 30 30 30 7522
North West Province Private and Aided Hospitals 16 16 351 986

ALL PROVINCES Institutions Licensed under
the Mental Disorders Act 36 - - 9344
Oral and Dental Hospitals 6- - 41
Mining Clinics and Hospitals 57 - - 4949
Tuberculosis Hospitals 22 - - 4260

TOTAL 822 161085

(Source: 2001 Hospital & Nursing Yearbook)

B. COMPETITIVE ANALYSIS

Local and Foreign Competition

Since the establishment of democracy, South Africa has seen companies from around the world introduce their products to South African distributors and end-users. As a result, many South African firms have had to adapt to genuine competition for the first time in years. To survive and to develop markets abroad, South African companies are taking steps to institute quality and cost controls, practice aggressive marketing techniques and become more customer and service oriented. Many will become competitive, but for products where price is the major factor, the devaluation of the Rand will ensure that inefficient industries will continue to operate.

There is useful information on the Internet - web page: www.medisource.co.za - regarding local, U.S. and 3rd country companies represented in the various health care sub-sectors (i.e. cardiology, dental and orthodontic, diagnostic and testing, etc.). Some European companies which are represented in the South African market are Siemens, Boeringer Mannheim, Brittan Healthcare, Glaxo Welcome, etc.

U.S. Market Position

Several major U.S. firms including 3M, Eli Lilly, Abbot Laboratories, Allergan South Africa, Arrow Africa, Johnson & Johnson, United HealthCare Corporations are represented in South Africa. The US Commercial Service also keeps a list of US companies represented in this market.

C. END-USER ANALYSIS

Approximately 90 percent of South Africa's population is located in the areas surrounding the cities of Johannesburg, Cape Town, Durban, Pretoria and Port Elizabeth, which represent the country's major areas of economic activity and major consumer markets.

Evaluating the current state of health and development in South Africa is no easy task. On the positive side, significant progress has been made in a number of health and development areas including improving literacy rates, raising life expectancy, falling infant mortality figures and greater immunization coverage. On the other hand, there is a lack of education, low economic growth, unemployment, lack of basic services and amenities, high poverty levels, inequalities in life chances, social instability, crime and violence, and the erosion of key social institutions and values. Superimposed on these are deep

inequalities and disparities in most of the health and development indices, accompanied by severe deprivation. The imminent threat of HIV/AIDS is perhaps the most important single factor in the larger health and development sector.

BEST PROSPECTS

Managed Care and Health Education

The compound rate of growth in health care costs has been estimated at over 20% over the last five years in both public and private sectors. The public sector is pursuing a major cost-cutting drive by reducing the number of secondary and tertiary health care facilities and concentrating on primary health care. In the private sector, managed healthcare organizations are focusing on the reduction of fraudulent medical claims, reducing hospital bed nights and on encouraging consumer spending patterns away from the more expensive branded pharmaceuticals towards generic equivalents. Multi-national pharmaceutical companies, bound by supply contracts from international parent companies, will find it difficult to break into the generic market. Their products are aimed at the declining higher end of the market. The opportunity for US companies lies in mergers and acquisitions of on-going South African companies who already hold a stake in the generic market

South Africa's private health care industry is large and highly developed, however it is estimated that only 20 to 25% of the population has regular access to this sector, and that private sector expenditure exceeds that of the public sector – estimated at 80% of the total healthcare expenditure. Given its capacity and relative technological advancement, broadening access to the private sector is recognized as an important step in improving the quality of healthcare available to all South Africans. There is a dire need for cost control in the medical aid industry, with special emphasis on doctors' consulting fees and drug costs. Managed Care is regarded as one of the best opportunities for U.S. companies interested in accessing the local healthcare market to joint venture with existing companies to transfer cost control information and technology.

Some analysts see opportunities in health education, training and consulting as a cost saving exercise for South African companies. An average-sized company in SA that provides fairly standard benefits spends about 10% to 15% of payroll on the direct cost of employee health through medical aid, group disability and group life benefits. Mounting health costs and downtime due to illness can be better controlled if employers link medical care issues to productivity and manage all health events affecting their employees.

However, companies do not measure indirect costs such as lost productivity due to employee absence, replacement employees and overtime. Recent studies estimate these costs to be in the order of four times the salary of employees for the duration of their absence.

Health analysts predict the future trend to be towards a benefit continuum with long-term cost control, improved productivity and a strong focus on employee health and wellness. They believe that this can be achieved through a company-based wellness culture, where the focus is on maintenance ‘rather than repair'. Companies need to shift their focus from purely medical scheme cost containment and managed care, to include the provision of timely and appropriate medical care, coupled with work programs to achieve a reduction in lost productivity costs and a reduction in health costs.

Public Private Partnerships (PPP):

Until recently, the government treated the public and private sectors as two distinct entities that could be managed independently. Experience has shown

that, if left unregulated, the private sector will infringe on public objectives. For example, the increasing exclusion during the course of the 1990s of high-risk individuals from health insurance and medical schemes: led to shrinking coverage in the private sector,
as well as the dumping of private patients on the public sector once their benefits had been consumed.
This increased the burden on the public sector, jeopardizing the quality of the care that could be provided to the truly indigent. This recent experience has led to an understanding that government needs to influence the behavior of the private sector through regulation, hence the enactment of the Medical Schemes Act of 1998. It is also recognized that government needs to seek out opportunities for constructive partnerships with the private sector in order to tap into the enormous resources at its disposal.

One form of public-private relationship is public financing of private sector care for public patients. In this arrangements, government financing is used to provide patients unable to fund their own care with access to services that are privately owned. Examples of this include the contracting out by government of clinical services to private sector providers such as diagnostic services, or of hospital care for the mentally ill and of non-clinical services such as laundry and catering services. Private medical practitioners working on a seasonal basis for the public sector and private nurses contracted to public hospitals also fall into this category.The value of such contracts at the hospital level alone is estimated to be over 10 percent of the total public hospital budget or as much as R1.58 billion (2000/02 prices).

The second form of public-private relationship is private financing of public care. In this case, private financing funds access to government-owned services. Out-of-pocket expenditures and medical scheme reimbursements for insured patients treated in public facilities are an example of this category. Also falling into this category is the leasing out of public beds and wards to private providers for the care of their patients, and forms of limited private practice where public sector doctors are allowed to spend some of their time caring for private patients. These latter arrangements involve the private sector management of publicly owned resources.

There is another form of relationship that occurs between the public and private sectors, namely, public financing of care (public or private) for private/insured patients. This relationship is in fact a form of subsidization by the state of private/insured patients and providers. It is considered controversial by some commentators, depending on whether they feel that patients who able to fund their own care should be entitled to also benefit from tax-funded services (to which they have contributed through income tax payments). Examples of this type of relationship include:
- charging of below -cost fees to private/insured patients using public facilities (this has been a major problem for at least a decade, as the outdated hospital user fee system bears little relation to the cost of providing care, let alone kept pace with inflation;
- tax rebates for employer and employee contributions to medical schemes;
- tax subsidies for the training of health care workers who work in the private sector;
- and some forms of limited private practice where state-funded resources are used for private/insured patients without reimbursement.

The above mentioned regulations hindered the government's goal of increased access to healthcare resources and improved efficiency. To address these issues, the National Department of Health set up a Public - Private Partnerships (PPP) Task Team in 1999.

Four major categories of PPPs were placed under consideration for further development by government:

purchasing services to obtain specialized skills or to meet short-term staffing needs;
outsourcing of services not seen as the core business of government (mainly non-clinical services);
joint ventures involving a sharing of resources between public and private partners resulting in the provision of increased or higher-quality services, or lower costs. This could be on a “service basis”, where clinical and support services are provided by public sector employees working on the ‘private side’ of a facility. Or on a “lease basis”, where the public sector leases space and/or equipment to the private sector and the private partner provides clinical and support services); and
private finance initiatives (PFIs) providing capital funding which is unavailable in the public sector.

All of these activities focus mainly on strengthening public hospitals and providing the public sector with access to expensive technology.

All nine South African provinces have autonomy over their healthcare budget and therefore determine their spending priorities. It is recommended that U.S. companies contact individual provinces directly regarding health sector tenders, trade issues and knowledge exchange. The relevant provincial authorities are listed under the "Key Contacts" header.

D. MARKET ACCESS

Barriers to Trade

South Africa is a signatory to the General Agreement on the Tariffs and Trade (GATT) and is a member of the World Trade Organization. U.S. products qualify for the Most Favored Nation rates. South Africa follows the Harmonized System (HS) for import classification.

In keeping with its WTO commitments, the South African Government has reformed its complex tariff structure by simplifying and reducing its overall tariff code such that the average tariff rate has fallen from a level in excess of 20 percent to just over 12 percent.

U.S. companies exporting to South Africa are subject to exchange control approval administered by the South African Reserve Bank. The Ministry of Trade and Industry is empowered to regulate, prohibit or ration imports to South Africa in the national interest, although most goods may be imported into South Africa without restriction.

Property Rights

Property rights, including intellectual property, are protected under a variety of laws and regulations. Patents may be registered under the Patents Act of 1978 and are granted for 20 years. Trademarks can be registered under the Trademark's Act of 1993 for periods of ten years, and can be renewed in ten-year increments. The South African Government passed two IPR-related bills in 1997 - the Counterfeit goods bill and the Intellectual Property Laws Amendment bill - to bring South Africa's laws into conformity with international trade obligations under the trade related intellectual property agreement of the WTO.

Market Entry Strategies

The Commercial Service in Johannesburg has found that the most successful U.S. companies in South Africa are those who have thoroughly researched their market potential before searching for agents or distributors. There are a number of

market research products and business contact services available from the Commercial Service in Johannesburg to assist U.S. companies with this process.

In South Africa's increasingly competitive marketplace, it is essential that the U.S. exporters provide adequate servicing, spare parts and components, and qualified personnel capable of handling training service inquiries. Industry analysts suggest that U.S. companies should consider joint ventures with South African companies in the supply of medical equipment as opposed to finding local distributors or establishing new companies. The following reasons were cited as a basis for this recommendation:
Medical equipment requires continuous maintenance service that should be available on-call. Established companies have structures in place, which deal with after-sale service.
Substantial amounts of capital would have to be invested in stock to start earning returns on investments.
Unless a product was unique to the US supplier, establishing a new company would be met with stiff competition from existing local businesses in the medical supply field.

The US product should, however, show an essential superior technology compared to the existing products.

Financing

South Africa's sophisticated financial sector has about 32 commercial and merchant banks that can provide overdraft facilities and about 13 merchant banks that can provide short or long term credit. Only banks deemed to be "authorized dealers in foreign exchange " can handle foreign trade payments.

There are approximately 40 foreign banks represented in South Africa. Key areas of business for foreign banks include trade finance, letters of credit, foreign exchange activities and services to offshore investors.

Letters of credit are the customary way to finance imports into South Africa. The most commonly used documentary credits are irrevocable credits and confirmed irrevocable credits. Trade finance insurance and project financing instrument are also available from a number of U.S. government agencies (the Export-Import Bank and the Trade Development Agency) as well as a number of private South African entities such as the Independent Development Corporation (IDC), Southern African Dvelopment Fund, Magic Fund, etc.

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